ABSTRACT

SOCIAL WORK

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A STUDY OF THE EFFECTS OF SOCIAL SKILLS TRAINING ON SELF-ESTEEM IN AN ADOLESCENT FOSTER CHILD

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of social skills training on self-esteem in adolescent foster youth utilizing the 10-item Rosenberg Self-Esteem Scale. The subject for this research was a 17 years old African American male in foster care.

This study hypothesized that social skills training, framed in cognitive restructuring, would increase the subject's level of competence (efficacy) and would result in a heightened sense of self-esteem.

The findings of this study concluded that social skills training was effective in increasing overall self-efficacy and self-esteem. The length of time for both baseline and intervention might have yielded different results.

A STUDY OF THE EFFECTS OF SOCIAL SKILLS TRAINING ON SELF-ESTEEM IN AN ADOLESCENT FOSTER CHILD

A THESIS

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CHAPTER ONE

INTRODUCTION

Self-esteem has been widely studied, discussed, and researched in relation to age, gender, race, ethnicity, social class, family background and academic achievements. In the developmental literature, self-esteem is discussed as developing during childhood and adolescence and continues throughout the life cycle. During childhood adolescence, teachers, parents and social workers are expected to act in ways that enhance the child's positive self-concept, feelings of worth, and a belief in social interpersonal and physical abilities.[1]

Those who have studied self-esteem suggest that children and youth who feel better about themselves demonstrate higher academic achievement and feel more confident in risking growth and change. Self-esteem increases as recognition of accomplishments and self-affirmation of one's performance is acceptable. However, outside recognition of one's achievements and perceptions of abilities is equally influential in establishing

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[1]Karla Miley, Michael Melia, and Brenda Dubois, Generalist Social Work Practice: An Empowering Approach, 2nd ed. (Boston: Allyn & Bacon, 1998).

self-esteem. As social workers and other professionals identify clients' strengths and achievements, they will enhance their clients' feelings of self-esteem. Good social skills help adolescents to develop friendships, communicate better with parents, teachers, and contribute to their overall self-concept.[2]

Self-esteem is generally regarded as a component of the overall self-concept, and is a set of complex beliefs about one's self, and represents how much a person likes, accepts and respects himself. Rosenberg regarded high self-esteem as an individual who respects himself and considers himself worthy; while an individual with low self-esteem implied self-rejection, self-dissatisfaction and self-contempt.[3] Bandura associated self-esteem with self-efficacy: one's belief about the ability to perform behaviors that lead to expected outcomes. This model suggested that when self-efficacy is high, the individual feels confident to execute specific tasks. When self-efficacy is low, individuals worry that the necessary responses may be beyond their abilities.[4]

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[2]Ibid.

[3]Morris Rosenberg, Carmi Schooler, Carrie Schoenbach, and Florence Rosenberg, "Global Self-Esteem and Specific Self-Esteem: Different Concepts, Different Outcomes," American Sociological Review 60 (1998): 141-156.

[4]Wayne Weiton, Psychology: Themes and Variations, 2nd ed. (California: Brooks Cole Publishing Co., 1994).

Self-esteem in adolescent development has been well documented. Rosenberg suggested that what a person thinks of him/herself determines the direction of social interactions and influences thoughts of self-evaluation in the individual's relationships with others. Self-esteem has been found to be associated with a range of childhood psychosocial developmental milestones, for example, academic performance, behavioral, environmental, and health related problems.[5] It is thus fair to assume the importance of the support of family, particularly parental involvement, in the development and sustainment of a youngster's healthy sense of self.

Adolescence is the developmental period during which youth transition from childhood to adulthood. While early adolescence (ages 12 to 14 years) has its own challenges, middle adolescence (ages 15 to 17) also has its own unique challenges and stressors. These years, ages 15 to 17, are characterized by demands for personal recognition. Although not ready for the responsibility of being an adult, there is resistance to being treated as a child. During middle

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[5]Allyce Holland and Thomas Andre, "The Relationship of Self-Esteem to Personal and Environment Resources of Adolescents," Adolescence 29 (1994): 345-360.

adolescence, adjustment problems peak and are associated with a heightened struggle for independence and identity.[6]

Identity development is a process which begins early in life and continues throughout the life cycle. It is shaped by influences, such as the social environment including family relationships, present and past experiences. The adolescent phase of identity development includes the attempt to negotiate systems and determine how best to fit into society.[7]

According to Weiton, the central task of the adolescence stage of development is the formation of a stable identity. The psychosocial crisis during this stage pits identity against confusion as potential outcomes, struggling to form a clear sense of identity.[8] Essential components of a healthy identity include the development of self-esteem, establishment of autonomy and independence from parents, ability to relate to individuals of the same and opposite sex, and commitment to and preparation for a

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[6]Marc Zimmerman, Laurel Copeland, Jean Shope, and T. E. Dielman, "A Longitudinal Study of Self-Esteem: Implications for Adolescent Development," Journal of Youth and Adolescence 20 (1997): 117-141.

[7]Juliet F. Harper and Elizabeth Marshall, "Adolescents Problems and Their Relationships to Self-Esteem," Adolescence 26 (1991): 799-808.

[8]Weiton, Psychology.

vocational career or employment.[8] Changes in cognitive processes and the arrival of formal operations promote personal introspection. Decisions about vocational direction require self-contemplation. An influential study by Coleman, Hertzberg and Morris suggests that the crucial question is not "Who am I?" but "Who will I become?" Therefore, adolescents are understandably preoccupied with concerns about themselves and their future.[9]

Adequate identity formation is the cornerstone of sound psychological health. Identity confusion can interfere with important developmental transitions that occur during the adult years.

Self-Esteem of Adolescents in Foster Care

According to Gil and Bogart's exploratory study of 100 children in foster care, the impact of foster care on overall functioning, development, and well being has not yet been adequately determined. Investigators have begun to provide some evidence that children in foster care experience severe functional impairment. These impairments include lowered self-esteem, poor academic achievement,

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[8]Sakinah W. Salahu-Din, Ph.D. and Stephan Bollan, Ph.D., "Identity Development and Self-Esteem for Young Adolescents in Foster Care," Child and Adolescent Social Work Journal 11 (1994): 124-135.

[9]Weiton, Psychology.

behavioral and emotional problems, and other health-related problems.[10]

According to the American Public Welfare Association, in 1995 there were approximately 500,000 youth in foster care. It is estimated that by the year 2000, this number could escalate to over 840,000. Foster care is defined as residence in a supervised setting away from the biological family. Placement of children in foster care is most often precipitated by stressful family circumstances. These stressors include child abuse and neglect, parental substance abuse and family homelessness. It is considered that such circumstances endanger a child and deem the biological parents unable to adequately care for the child as mandated by social services and the juvenile justice system.[11]

It is reported that adolescents comprise the majority of young people in foster care. According to the American Public Welfare Association, 42.4% of youth in foster care are between the ages of 13 to 18 years.[12] These youth are particularly at risk for antisocial acting out. Antisocial

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[10]Susan Lyman and Gloria W. Bird, "A Closer Look at Self-Image in Male Foster Care Adolescents," Social Work 41 (1996): 85-96.

[11]Brenda McGowan and Emily States, "Children in Foster Care," Encyclopedia of Social Work, 19th ed. (Washington, DC: National Association of Social Workers," 1995).

[12]Ibid.

behavior in children encompasses aggressive acts, vandalism, theft, lying, firesetting, and a number of other violations that reflect major social rule violations. Petty and serious crime, drug use, irresponsible sexual behavior, academic underachievement, truancy, unemployment, and underemployment reflect the impulsiveness and inability to defer gratification that is characteristic of undersocialized youth.[13] Most youth experiencing foster care are placed in dependency relationships outside of their family origin. Upon removal from their families, certain normative developmental pathways toward self-sufficiency are altered for these youth.

Statement of the Problem

Frequently, adolescents in foster care have suffered from early familial losses, ongoing conflicts, and/or undesirable integration into surrogate families, making them particularly vulnerable to low self-esteem and the resulting poor self-concept.[14] Within the foster care system, adolescents receive less one-to-one parental attention than younger children in care. They often reside in group homes

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[13]Alan Kazdin and Karen Esveldt-Dawson, "The Interview for Antisocial Behavior: Psychometric Characteristics and Concurrent Validity With Child Psychiatric Patients," Journal of Psychopathology 8 (1986): 289-303.

[14]Antronette Yancey, "Identity Formation and Maladaption in Foster Adolescents," Adolescence 27 (1992): 819-831.

because of unmanageability, past placement instability, or the frequent unwillingness of foster parents to accept adolescent youth. There is an enormous disparity between actual care given in fostering these at-risk youth and the necessary parenting for their success.[15]

The lack of affective parenting, poor schools, environments, denigrating authority figures, abusive law enforcement, negative media depiction of people of color, disproportionately greater attention to negative events involving minorities, along with centuries of historical distortion, exert these youths' destructive influences unchallenged.[16] Thus, having been discarded or part of a problem family, as well as their status as a foster child as a constant reminder adversely affects foster youths' personal identity achievement.

Barth suggests that youth who are dealing with critical life transitions be placed at high risk for continued dependency on the community well into their adult lives. This continued dependency is most evident in the welfare entitlement system and/or periods of institutionalization. Jackson and Westmoreland's study

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[15]Gary Mallon, "Junior Life Skills: An Innovation for Latency Age Children in Out of Home Care," Child Welfare 71 (1992): 585-591.

[16]Stephan Gavazzi, Keith Alford, and Patrick McKenry, "Culturally Specific Programs for Foster Youth," Family Relations 45 (1996): 166-174.

indicated that because of the declining economic opportunities within most metropolitan environments, urban youth are at an even greater risk for continued dependency.[18]

One response to preparing youth for independence has been the use of life skills and social skills training interventions within independent programs that are designed to directly facilitate the youth's movement towards adult competency, prior to emancipation. Self-competency is most often equated with one's ability to graduate from high school, locate and maintain stable employment, access appropriate health services, avoid premature parenthood, and establish a social network, all of which fosters the development and maintenance of a positive self-concept.[19] Poole and Evans suggested that activities of independent living programs have observed significant relationships between the exposure of life skills training programs and the accomplishment of self-competency.[20]

The literature identified major life skill areas that were considered to be of most concern to adolescents. These included personal relationships (peers, family, relatives,

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[18]Ibid., 166.

[19]Millicent Poole and Glen Evans, "Adolescents' Self-Perception of Competence in Life-Skill Areas," Journal of Youth and Adolescence 18 (1989): 147-173.

[20]Ibid.

and opposite sex); communication (transactional, expressive, and nonverbal); relationship processes (cooperation, interpersonal understanding, and belonging); life course activities (education, job, leisure); personal development and self management (self-motivation, self-esteem, use of time, and coping with problems); social awareness (social responsibility, conscience, and altruism); and learning to learn.[21]

Social skills training programs have been used for both primary prevention and remediation of deficiencies. The rationale for preventive programs is that efforts to prevent social dysfunction by equipping people with coping skills reduces the possibilities of later maladjustment, unhappiness, failure to develop potentials, loss of productivity, and low self-esteem.[22]

Social dysfunction is commonly associated with deficiencies in social skills essential to achieving self-esteem, forming satisfying interpersonal relationships, and performing various social roles effectively. Deficiencies in social skills contribute to difficulties involving loneliness and depression, marital dysfunction, parent-child

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[21]Ibid., 147.

[22]Dean Hepworth and JoAnn Larsen, Direct Social Work Practice: Theory and Skills, 4th ed. (California: Wadsworth Inc., 1993).

problems, family breakdown, employment problems, and various mental health problems.[23]

Social skills training for adolescents has been associated with enhanced self-esteem, improved problem solving skills, and drug refusal.[24] Assertiveness is the social skill that is defined as expressing one's own rights and opinions with respect for others. Social skills training can include skill instruction, modeling, role-playing and performance appraisal. Along with behavioral modification, social skills training can modify distorted perceptions about social interactions as well as modify the individual's ability and potential.[25]

Review of the literature suggested that self-esteem is determined by one's social environment, relationships, and life events from the past and present. While youth in foster care face the same developmental issues as those not in foster care, their struggles for mastery of skills are challenged by the disruption caused by separation from their biological families. These struggles are sometimes unresolved and are revisited in other stages across the life cycle. Such issues become highly complex and complicated

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[23]Ibid.

[24]Kathryn Thompson, Kaare Bundy, and Wendy Wolfe, "Social Skills Training for Young Adolescents: Cognitive Performance Components," Adolescence 31 (1996): 505-521.

[25]Michael K. Reed, "Social Skills Training to Reduce Depression in Adolescence," Adolescence 29 (1994): 293-302.

for these youth resulting in low to poor to no life skills and a readiness for the world of adulthood which leads to a sense of poor self-esteem. Thus, these youth arrive in foster care settings with social, personal and academic success, a self-perception all of which represents a low sense of worth. Numerous studies support the view that self-esteem and self-efficacy are related. Intervention models for adolescent youth with low self-esteem and poor sense of efficacy are able to make strides through the use of social skills training framed in cognitive restructuring where the self belief system is challenged to grow and change.

Purpose of the Study

The purpose of this study was to determine the effects of social skills training activities, supported by cognitive restructuring techniques to increase self-esteem in adolescent foster youth.

CHAPTER TWO

LITERATURE REVIEW

Self-esteem in adolescence is influenced by the social environment, family relationships, present and past life events. Children in foster care face the same developmental challenges as children who reside with their biological parents. However, their struggles for mastery take place within the context of emotional stress generated by separation from biological parents. To facilitate a youth's ability to live successfully upon leaving the foster care system, adequate achievement of developmental tasks of adolescence is necessary. Social skills training in adolescence has been associated with enhanced self-esteem, improved problem solving skills, drug refusal and sex refusal.[1]

This section addresses theoretical framework and significant literature on adolescent self-esteem and self-esteem of adolescents in foster care.

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[1]Thompson, Bundy, and Wolfe, "Social Skills Training for Young Adolescents," 505-521.

Theoretical Framework

This study draws upon the self-attribution theory. The self-attribution theory concerns how people make judgments about their own behavior.[2] Considerable research has found that people typically attribute behavior either to stable personality characteristics, termed dispositions, or to the situations that were present at the time the behavior occurred.

Rosenberg's perspective of self-attribution posits that people form conclusions about themselves by observing their own performances and attainments. These standards for such self-evaluations are derived from social values and expectations. The meaning assigned to one's observation of self is of foremost importance. The perspective of self-attribution considers achievements as generated by internal motivation and not by external forces. Rosenberg and Pearlin used the principle of self-attribution to explain the absence of relationship between social class and self-esteem in youth. According to Rosenberg, a youth's personal achievement influences the development of self.[3]

Bandura suggested that many components are necessary for making use of acquired knowledge to produce a desired

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[2]Richard Dukes and Ruben Martinez, "The Impact of Ethgender on Self-Esteem Among Adolescents," Adolescence 29 (1994): 105-115.

[3]Rosenberg, Schooler, Schoenbach, and Rosenberg, "Global Self-Esteem and Specific Self-Esteem," 141.

behavior. According to Bandura, in order to choose assertive behavior, a person must interpret the situation as indicating that desirable consequences are available as a result of that behavior. Another component is the individual's self-efficacy for assertive behavior.

Bandura's construct of self-efficacy implies that a person must believe in the potential to make the appropriate assertive response if they choose this response.[4] Coupled with ideas from self-attribution and self-efficacy, this research project was also grounded in cognitive restructuring techniques. Cognitive restructuring is particularly useful in assisting clients to gain awareness of self-dysfunctional and self-defeating thoughts and misconceptions that impair personal functioning and to replace them with beliefs and behaviors that are aligned with reality and lead to enhanced functioning. Cognitive restructuring involves several steps:

1. Assisting clients to accept that their self-statements, assumptions, and beliefs largely mediate their emotional reactions to life's events;

2. Assisting clients to identify dysfunctional beliefs and patterns of thoughts that underline problems;

3. Assisting clients to identify situations that engender dysfunctional cognitions;

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[4]Ibid., 141.

4. Assisting clients to substitute functional self-statements in place of self-defeating cognitions; and

5. Assisting clients to reward themselves for successful coping efforts.[5]

Significant Studies

Literature cites parental support, control, and participation as critical antecedents to self-esteem. In Greenberg's study of 213 adolescents ranging from 12 to 19 years of age. Provision was made to examine the differential impact of attachment relationships with parents and peers on self-esteem. Greenberg found that the relationship with one's parents has a greater influence on self-esteem than the influence of peers on self-esteem, during adolescence.[6]

Brandeld noted that central to the concept of person-in-environment is the individual's ability to develop relationships and attachments. Among those relational aspects of person-in-environment interactions is human relatedness, competence, self-direction, and self-esteem, all of which are outcomes of the person-in-environment frame. While these attributes exist in all cultures, it is

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[5]Hepworth and Larsen, Direct Social Work Practice.

[6]Janis Patterson, Jan Pryor, and Jeff Field, "Adolescent Attachments to Parents and Friends in Relation to Aspects of Self-Esteem," Journal of Youth and Adolescence 24 (1995): 365-376.

important to understand the value placed on attributes of each client.[7]

Demo, Small and Savin studied 139 parents an adolescent youth between the ages of 10 and 17 years, and examined the effects of parent-adolescent communication as predictors of self-esteem in the adolescent parent relationship. Self-esteem was measured by the use of the "Rosenberg Self-Esteem Scale." Their findings suggested that adolescents and their parents have distinct perceptions of their relationships; and self-perceptions of these relationships, especially self-judgement of communication were found to have the most important predictable level of self-esteem for both adolescents and their parents.[8]

In other research, Ho, Lempers, and Clark-Lempers used the "Rosenberg Self-Esteem Scale" to measure the effects of economic hardship and parental support on self-esteem in adolescents. They found that economic hardship reduced affective parental support and may have conveyed a negative appraisal of the adolescent, lowering his or her

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[7]Jerrold Brandeld, Theory and Practice in Clinical Social Work (New York: The Free Press, 1997).

[8]David Demo, Stephen Small, and Ritch Savin-Williams, "Family Relations and Self-Esteem of Adolescents and Their Parents," Journal of Marriage and the Family 4 (1987): 705-715.

self-esteem and was found to be more important for the development of social competency and intimacy.[9]

Gil and Bogart's study of 100 children in foster care suggested that adolescents in foster care had a lower self-esteem than those not in foster care. The self-esteem of youth in family foster care was higher than youth in group homes or institutionalized care.[10] In contrast, Beyer's study of adolescent youth in foster care examined the difficulties youth experienced in transition to independence. These difficulties were attributed to the lack of strong relationships in their lives. For adolescents in foster care, these strong relationships may develop in the foster placement, but only in those circumstances that offer the opportunity to develop them. The mutual negative effects of separation and placement can be counteracted by a stable foster placement. The length of time in a current placement is an indicator of stability and indicates the length of time that youth have to adjust to a new environment and to form new supportive relationships that can help promote a positive self-concept.[11]

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[9]Camilla S. Ho, Jacques D. Lempers, and Dania S. Clark-Lempers, "The Effects of Economic Hardship on Adolescent Self-Esteem: A Family Mediation Model," Adolescence 30 (1995): 117-131.

[10]Lyman and Bird, "A Closer Look at Self-Image," 85.

[11]Ibid.

Some research findings suggest that the foster care experience may affect African American, other ethnic groups and white youth differently. African Americans, Native Americans, and Latino youth are overrepresented in foster care in the McShane research. Aside from higher representations in foster care placement, precipitant of poverty, homelessness, substance abuse, and youth from these ethnic groups are more likely to be removed from their families than are whites in similar circumstances. This representation is higher due to the diversity in cultures of the ethnic minorities. Often without maltreatment or neglect being confirmed, children of color are removed from their homes due to misinterpretations of one's culture or beliefs.

Hughes and Demo studied a sample of African Americans and examined the two major dimensions of self-perception: self-esteem, with personal and racial components, and personal efficacy. Personal efficacy was defined as an individual's competency, or ability to function effectively and productively in the world. Interpersonal relationships were identified as forming the foundation for self-perception, also termed self-concept or self-image. While self-esteem is most influenced by micro issues such as social relations with friends, family, and community, personal efficacy is developed from macro social comparisons. In contrast to Hughes and Demo's research,

Powell's research on African Americans found that Blacks have relatively high self-esteem, but low personal efficacy.[12]

Festinger examined former foster youth between the ages of 18 and 21 years, to provide a detailed picture of young adults who were discharged from foster care after reaching the age of 18. This study focused on what youth had to say about their experience in foster care, and their thoughts about what might improve such care. Festinger's research concluded that former foster care youth were generally satisfied with their lives and had a positive sense of well being as measured by the Rosenberg Self-Esteem Scale.[13]

Some suggest that a relationship exists between self-esteem and a sense of self-competence and/or self-efficacy. Using Rosenberg's Self-Esteem Scale, Owens, Mortimer, and Finch studied 222 males between the ages of 15 to 23 and examined the effects of self-determination as a source of self-esteem in adolescence. Self-determination was defined as one's independence. This research focused on the interrelations of the sense of self-determination, school achievement, and self-esteem. The researchers hypothesized that the greater the perception of self-determination in the

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[12]Yancey, "Identity Formation and Maladaption," 819.

[13]Trudy Festinger, No One Asked Us (New York: Columbia Press, 1983).

three contexts (self-determination, school achievement, and self-esteem), the more positive the impact on a youth's sense of self-esteem and worth. The findings of this study concluded that the stability of the self-determination constructs indicates considerable continuity in adolescent experiences in the family and at school.[14]

Poole and Evans, in a study of 1061 adolescents between the ages of 15 to 17 years, examined adolescents' perceptions of competence in life skill areas, and how they relate to their concerns and aspirations. These perceptions of competence were in terms of the usual educational context in which adolescents find themselves. Self-perception of competence was related to self-efficacy and to the value assignment of life skills. Three sets of scales were used, those concerned with competence viewed as self-efficacy in various life areas and situations, those concerned with competence as the satisfaction of goals based on Maslow's hierarchy of needs, and assessments of the structural complexity of performance on a short essay task. Poole and Evans concluded that females underrated their own competence. The major educational or work contexts reflected important differences in patterns of self-perception of skill. The general findings were that self-

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[14]Timothy Owens, Jeylan Mortimer, and Michael Finch, "Self-Determination as a Source of Self-Esteem in Adolescence," Social Forces 74 (1996): 1377-1404.

perceptions of competence in life skill areas tend to be global rather than domestic specific if there is an underlying sense of self-esteem.[15]

Wise and Buddy studied the acquisition of assertiveness in adolescents using a social cognitive approach. They found that adolescents could learn more and could retain cognitive information that was basic to understanding the concept of assertion. According to Bandura's social cognitive theory, this acquisition of symbolic representation is only the first step in changing behavior. Bandura suggests that many components are necessary for making use of acquired knowledge to produce a desired behavior, such as social cues.[16]

Social skills training is designed to alter maladaptive social and interpersonal behaviors, as well as inappropriate cognitive evaluations associated with social behavior. Appropriate social skills consist of the ability to organize cognitions and behaviors into an integrated course of action directed toward culturally acceptable social and interpersonal goals, and the ability to continuously assess and modify goal-directed behavior to maximize the likelihood of reaching particular goals.

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[15]Poole and Evans, "Adolescents' Self-Perception," 147.

[16]Thompson, Bundy, and Wolfe, "Social Skills Training for Young Adolescents," 505.

Definition of Terms

Adolescence: the developmental stage between 12 and 18.

Life skills: skills required to live independently.

Self-attribution: judgements one makes on his own behavior.

Self-competency: goals that one has for himself; a process of moving from dependence to independence.

Self-efficacy: an individual's competency, or ability to function effectively and productively in the world.

Self-esteem: how a person feels about himself; a personal judgement of worthiness that is expressed in the attitudes the individual holds towards himself.

CHAPTER THREE

METHODOLOGY

This chapter is organized in the following manner: research design, instrument, sample, intervention strategy and plan, and procedure.

Research Design

This research project utilized a single system A-B design. Bloom, Fisher and Orme describe the A-B design as control over various factors in order to determine relationships among events. This causal relationship helps to make effective practice decisions through two phases. The A phase, or baseline period, is measured before the intervention is applied. The B phase occurs when the intervention is introduced in order to change the behavior.[1]

In the current study, the A phase, baseline of the A-B design was the time during which the subject's target problem of low self-esteem was observed and monitored. In this phase, no attempt was made to effect any changes in the

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[1]Martin Bloom, Joel Fisher, and John Orme, Evaluating Practice: Guidelines for the Accountable Professional (Massachusetts: Allyn & Bacon, 1995).

subject's targeted problem. The objective of this phase was to simply measure and monitor the subject's level of self-esteem.

The B phase, intervention of the A-B design, utilized social skills training and was composed of planned separate but related activities. These activities consisted of modeling and rehearsal of effective communication skills, positive interaction, conflict resolution, which empowered the client toward more thoughtful decision making. During the B phase data were collected on the same targeted problem as the A phase. This data collection method is referred to as repeated measures.[2] The assumption underlying the A-B design is that the problem observed during the baseline would continue in the same pattern, if no changes were made in forces acting on the problem. The intervention was a planned change to modify problematic events existing before the intervention.

Instrument

The data for this study were obtained by using the Rosenberg Self-Esteem Scale (RSES). The 10-item self-esteem scale required the subject to report feelings about himself

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[2]Ibid.

directly. The RSES measures an individual's sense of self-worth and value placed in competency or efficacy.[3]

Rosenberg's Self-Esteem Scale is scored by a four-point Likert scale (strongly agree, agree, disagree, strongly disagree). Questions 1, 3, 4, 7 and 10 represent what Rosenberg refers to as the value that one places on himself/herself, one's sense of worth. Questions 2, 5, 6, 8 and 9 represent what Rosenberg refers to as a sense of competence (efficacy). Low self-esteem responses are "disagree" or "strongly disagree" on questions 1, 3, 4, 7 and 10, and "strongly agree" or agree" on questions 2, 5, 6, 8 and 9. This scale has a test-retest reliability of .80-.95. The 10-item scale has been used in numerous studies, and can be administered in 2-3 minutes. This scale is significant for any project using changes in self-esteem as a dependent measure to document client change. This brief index can be easily included in interviews or be used as a separate form.[4]

Subject

The subject used in the present study was an African American adolescent male, 17 years of age. Earl's participation in this study was in conjunction with the

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[3]Rosenberg, Schooler, Schoenbach, and Rosenberg, "Global Self-Esteem and Specific Self-Esteem," 141.

[4]Ibid., 141.

Department of Family and Children Services' Independent Living Program. Earl had a history of poor academic achievement, substance abuse, and crimes committed by deviant behavior.

Earl is the oldest of three children. He was abandoned six times by his biological mother, since age five. His biological father was unknown. Being the oldest and left to care for two smaller children, Earl began stealing to survive. Initially, Earl stole food and clothing for himself and his younger sisters. As he grew older, he began to steal cars and sold drugs to earn money. After living alone for several months, Earl's maternal grandmother took guardianship of him. At age 12 guardianship was transferred to his maternal aunt.

Earl's sense of efficacy was demonstrated by poor reading skills due to multiple truancies and expulsions from school. Earl has poor socialization skills due to his inability to trust others. Earl does not have any friends; he referred to his peers as associates. During a pre-interview session, Earl stated, "I don't need nobody, but me. I don't need no friends." Earl appeared to be very angry. He had difficulty keeping eye contact, and when he became upset, he used profanity.

The results of a recent psychological evaluation, performed by the Department of Family and Children Services, provided evidence and support for Earl's low self-esteem.

The evaluation also revealed that Earl's intelligence was average; however, his lack of self-confidence contributed to his inability to complete assigned tasks.

Intervention Strategy and Plans

In this study, the intervention strategy was in the form of a social skills enhancement package, specifically designed to facilitate personal growth/efficacy and self-esteem. Social skills training activities should reflect the precise social skills deficits that the subject exhibits.[5] Earl's social skills deficits were categorized into two groupings: poor communication skills, poor judgment and decision making.

These deficits for Earl were exhibited by poor social interaction, whereby there was a lack of eye contact, head held in a downward position; verbal responses were expressed as "I don't know," when in fact, he did hold an opinion, feelings and thoughts; constant body motion, looking away conveying lack of interest. These attributes resulted in an inability of Earl to form significant and meaningful relationships. The second category of Earl's social skills deficits, addressed in the intervention were in the area of poor judgment and decision making. His actions and behaviors indicated no prior planning, resulting in

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[5]Thompson, Bundy, and Wolfe, "Social Skills Training for Young Adolescents," 505.

oversleeping and not reporting to school; deliberate violation of house and program rules which warranted reprimands and demerits, ultimately placement disruption.

This study used cognitive restructuring to frame intervention activities in assisting Earl to strengthen his personal power. These activities included lessons on such topics as improving the subject's communication skills to increase positive interaction, and conflict resolution to resolve issues which empowered toward thoughtful decision making. During each session, the practitioner modeled behavior and encouraged Earl to rehearse this behavior by giving him assignments in which he had to demonstrate skills he learned from previous lessons. Video presentations covering selected topics were used to reemphasize skills to be rehearsed. These videos encouraged further development of new skills and behaviors to be performed.

The intervention of activities were designed to promote goal planning for the future. Each session challenged Earl's negative belief system. The practitioner providing praise for task accomplishment and general positive affirmations encouraged positive interaction and allowed Earl to explore and acknowledge his own personal strengths. To encourage Earl's motivation to complete established goals, certificates of achievement were offered once goals had been completed.

Treatment Hypothesis

This study hypothesized that social skills training, framed in cognitive restructuring, would increase the subject's level of competence (efficacy) and result in a heightened sense of self-esteem.

Procedures

Sessions for this study were conducted during regular school hours at one of the Fulton County area offices. The coordinator of the Independent Living Programs arranged for excused absences from Earl's school. These approved absences were classified as educational activities, which would be beneficial to his sense of well being, with expected outcomes of better social, academic and personal development.

Earl was expected to attend bi-weekly sessions, participate and complete all assigned tasks. Transportation was provided by the agency. Sessions were conducted on alternating Tuesday afternoons from 3:00 p.m. to 5:00 p.m.

Session 1: Introduction

During the first session, Earl and I became acquainted. Expectations and procedures outlining what he could expect from the experience and what was expected of him were explained. The subject was presented with a schedule of the next seven sessions. Earl signed a copy of the session schedule denoting the acceptance of the terms

and expectations. By agreeing to meet these expectations, Earl understood that the goals of the Independent Living Program, in which he was enrolled, were also being addressed. The goal of the Independent Living Program was to assist youth in developing life skills for independent living.

Session 2: First Day of Baseline

This session was the first day for the baseline measurement. The subject completed the Rosenberg Self-Esteem Scale. Following the administering of the Rosenberg Self-Esteem Scale, the practitioner spoke with Earl about his progress in the Independent Living Program in terms of achieving goals toward independence. It was explained that the opportunity to meet with the practitioner over the next seven (7) sessions would provide him with individual attention and support towards achieving these goals.

Session 3: Communication Skills

In this session, the first intervention was introduced, which highlighted the client's personal strengths. During this session, the subject was encouraged to identify positive characteristics about himself in preparation for developing positive affirmations. Following this activity, the subject was introduced to a lesson on effective self-expression and communication skills. The practitioner defined communication, its process, and types

of messages that are received from non-verbal communication, i.e., body language, facial expression, voice and tone, eye contact, postures/gestures, image and appearance. Earl was asked to discuss what non-verbal habits he wanted to change. Earl was provided with guidelines for delivering healthy messages, criticisms, and types of listening. Following this exercise, the subject and practitioner participated in a role play, modeling examples of poor and effective communication skills. At the conclusion of this activity, the subject was asked to complete the Rosenberg Self-Esteem Scale.

Session 4: Interview with Job Corp

During the fourth session, the subject was interviewed by a representative from Job Corp. This session's focus facilitated positive interaction. The subject was asked to formulate at least one question to be answered by the Job Corp field services representative. He was encouraged to use communication skills learned in the previous session. After the speaker left, the subject was asked to discuss what types of communication he used and how it affected the interview. Following this discussion, the subject was asked to complete the Rosenberg Self-Esteem Scale.

Session 5: Field Trip With the Independent Living Program (ILP)

The fifth session was conducted outside the agency. The ILP participants were taken to a local pizza restaurant to eat and to promote social skills. As the subject ate, he was asked to engage in at least two conversations with two other people he did not know. He was given an assignment to introduce those two people to the entire group. Following this outing, the subject completed the Rosenberg Self-Esteem Scale.

Session 6: Conflict Resolution

This session's focus was learning to communicate effectively with sources of conflict, working toward a solution in a peaceful way. The practitioner asked the subject to define his concept of conflict, positive and negative. Next, it was explained to Earl that conflict is neither positive or negative but is a normal process of daily life. Earl was taught the conflict cycle, which begins with the beliefs and attitudes that determine how one acts, reacts, and responds to conflict. How one acts, reacts, and responds dictate consequences one has and reinforces his/her beliefs and attitudes. The practitioner identified types of conflict and explained each to the subject, i.e., intra-personal conflict, interpersonal conflict, intra-group conflict, and intergroup conflict. To further this activity, the practitioner identified causes of

conflict, resources, psychological needs, and values. The practitioner reemphasized the importance of communicating one's feelings by sending less threatening messages, "I messages," as opposed to "You messages," as well as the benefits of active listening. Accompanying this activity was a 20-minute video presentation covering techniques teenagers can use to resolve conflict non-violently. Following this activity, the Rosenberg Self-Esteem Scale was administered.

Session 7: Presentation from the Independent Living Program

A life skills presentation served as the intervention activity for this session. The subject was asked to formulate at least one question to ask the ILP coordinator. The coordinator identified services and programs available to Earl. These services are aimed at assisting Earl to become self-competent or independent. The goal of this session was to empower Earl by providing him with information and support in developing life skills. Concluding this presentation, the subject was administered the Rosenberg Self-Esteem Scale.

Session 8: Final Session

During the final session, the subject was asked to list six positive affirmations on a piece of paper and place them into an envelope. He was then asked to randomly select

three self-affirmation statements from the envelope and read them aloud. At the end of the session the final Rosenberg Self-Esteem Scale was administered. Earl was also given a certificate of achievement for the progress made during the sessions.

Following the eighth session, this study was concluded. However, Earl plans to continue setting and achieving goals for himself. This experience has restored Earl's confidence, and has motivated him to focus on his strengths instead of barriers to successful achievements.

CHAPTER FOUR

PRESENTATION OF FINDINGS

In this study, the subject responded positively to the intervention. Certificates of achievement were offered as incentives to the subject once he completed established goals. Approval, praise, and expressions of affirmation were used in every session as positive reinforcers. Trust was established easily with the subject who responded freely in conversation and was eager to participate in bi-weekly sessions. Each session focused on the subject's strengths, which facilitated development of his motivation and participation.

Baseline Results

Following the introductory session, a baseline measurement of the subject's self-esteem was taken in Session 2, utilizing the Rosenberg Self-Esteem Scale. The same test was then repeated at subsequent sessions to acquire repeated measures. A decision was made to have no more than one baseline due to previous reports from the Department of Family and Children Services which reported observations of low self-esteem. These observations of low self-esteem consisted of poor eye contact, head held in a

downward position, constant body movement and looking away, conveying lack of interest when interacting with peers and adults. These observations were supported by psychological testing, conducted prior to this research study. Results of the baseline measures are indicated in Figure 1. Low self-esteem responses were "disagree" or "strongly disagree" on items 1, 3, 4, 7 and 10, and "strongly agree" or "agree" on items 2, 5, 6, 8 and 9. The responses were combined and the mean scores were charted for each session.

Figure 1

Figure 1 represents a graphic portrayal of the subject's combined responses of self-worth and competence/efficacy on the Rosenberg Self-Esteem Scale during the baseline session. The subject responded 4, strongly disagree on items 1, 3, 4, 7 and 10. These combined responses indicated the value that Earl placed on himself. The subject responded 1, strongly agree on items 2, 4, 6, 8 and 9, which combined responses represented Earl's sense of self-competence/efficacy.

Intervention Results

Figure 2

Figure 2 is a graphic representation of the subject's combined responses to items of self-worth and self-competence/efficacy on the Rosenberg Self-Esteem Scale, during the intervention sessions. The baseline responses

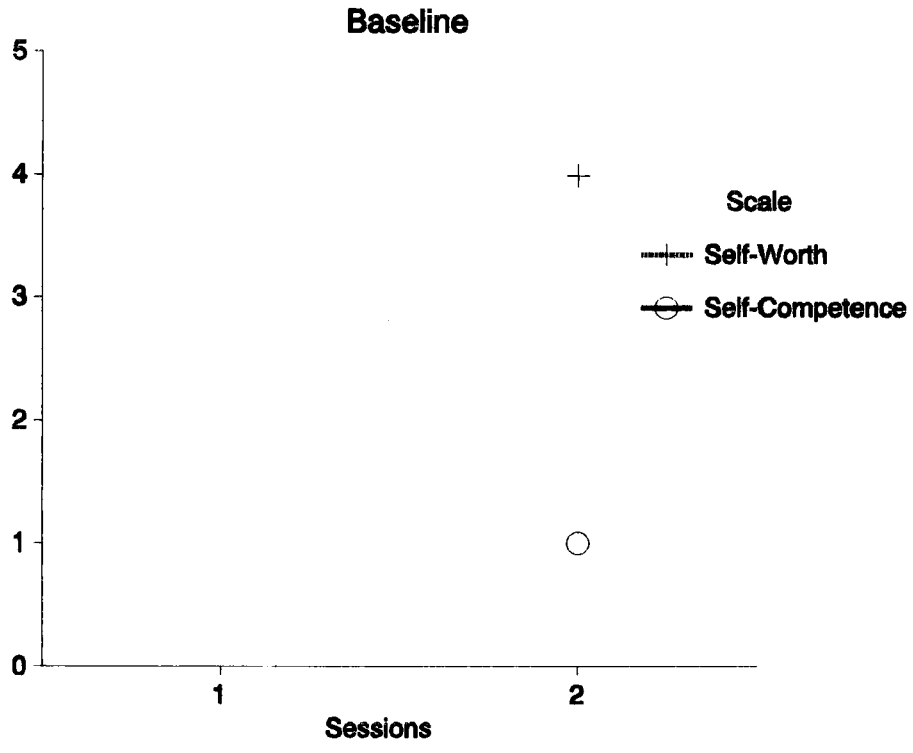

Figure 1. Assessment of Self-Worth and Self-Competence/ Efficacy

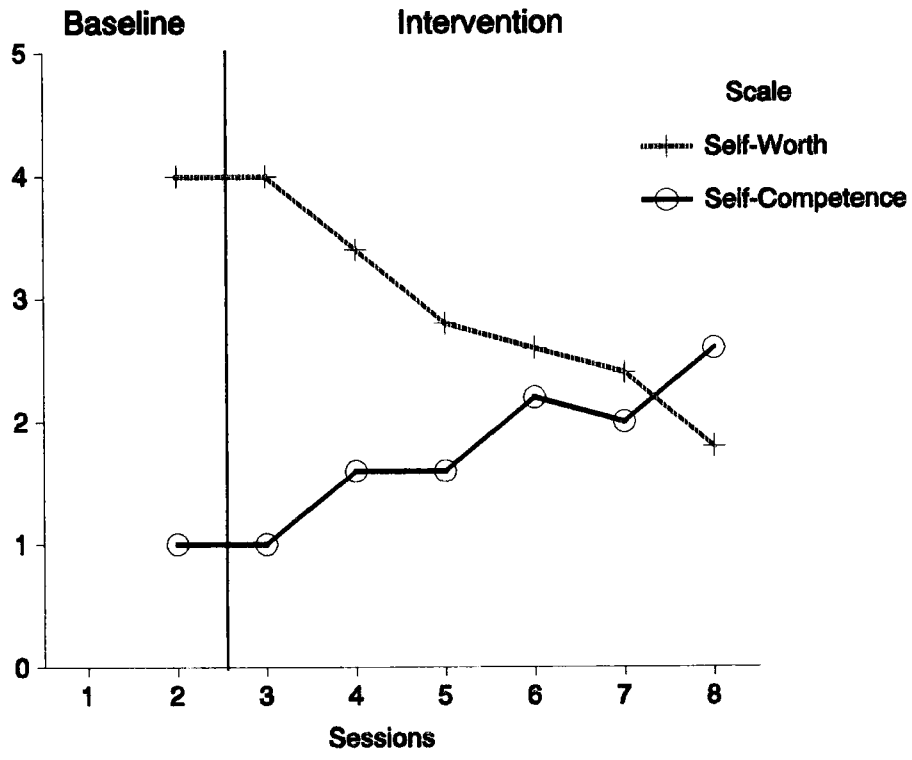

Figure 2. Assessment of Self-Worth and Self-Competence/ Efficacy

for self-worth and self-competence/efficacy indicated Earl had a low level of self-esteem. Repeated measures consistently supported these findings. As the interventions progressed, the value that Earl placed on himself increased. This was indicated by lower scores for each session. At the closure of the study, Earl's sense of self-worth increased. His self-rating lowered from a high 4 in the baseline to a lowered 1.8 in the final session. Earl's sense of self-competence/efficacy was also increased as the intervention progressed. This was indicated by his responses of higher ratings during each session. At the onset of the study, Earl responded 1, which indicated low self-esteem. At the conclusion of the study, Earl responded 2.6, which indicated although his level of self-esteem was still low, it had increased since the baseline session. Therefore, the findings of this study support the hypothesis that Earl's increased sense of self-competence/efficacy would heighten his feelings of self-esteem.

CHAPTER FIVE

DISCUSSION

The findings of this study suggest social skills training can be an effective method of increasing self-esteem in adolescent foster youth.

Adolescence is a difficult period for many youth, particularly foster children. Deficits in social skills may increase the problems of these youth. One recent approach to dealing with youth problems is social skills training.[1] This approach emphasizes training adolescents in specific pro-social alternative responses for problematic situational interactions. The literature has indicated that social skills training can lead to behavioral and cognitive changes in youth.

In this study, the overall social skills training increased the subject's self-esteem. The subject felt that he had improved, especially with his communication skills. Areas of difficulty continue with interpersonal relationships. Referrals to counseling services may assist

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[1]Thompson, Bundy, and Wolfe, "Social Skills Training for Young Adolescents," 505.

this client in coping with the anger and resistance that he is harboring internally.[2]

Behavioral rehearsal of coping strategies developed through this social skills training intervention may have a significant influence on the subject's future ability to self-evaluate and respond to external stressors. The subject appears to have become more goal oriented. At the beginning of the study, the subject found it to be difficult task, planning ahead. He has learned the task of setting and obtaining short-term goals, he has established long-term goals of obtaining his G.E.D. and enrolling in a technical program.

Suggestions for Future Research

A recommendation for future research would be to utilize social skills training for a longer period of time. The longer sessions will allow the practitioner time to gauge whether there are underlying issues that need to be addressed. As well as, the length of time the intervention is effective.

Another recommendation includes utilization of social skills training in group and individual sessions. Withdrawn or highly disruptive individuals may respond better if they are first introduced to social skills training

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[2]Ibid.

individually.[3] Once the individual feels confident, a group setting would provide for positive peer relations to develop. The feedback the individual can receive from a group setting can compliment skills learned during an individual social skills training program.[4]

Limitations of the Study

This study was limited in that the research design was an A-B design. An A-B design consists of collecting baseline data followed by the intervention. With this design, it is difficult to conclude the actual cause of improved self-esteem. A better design may have been the A-B-A design, which specifically incorporates a maintenance phase into the study; however, with time restraints, the A-B-A design was not feasible for this particular study.[5]

The Rosenberg Self-Esteem Scale indicated that an increase in self-esteem occurred when social skills were enhanced. Social skills were enhanced through the subject's involvement with the Independent Living Program group. The sustaining behavior of the group provided the subject with an avenue to socialize, learn and to practice new behaviors in a safe and controlled environment. The duration of the

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[3]Ibid., 505.

[4]Hepworth and Larsen, Direct Social Work Practice.

[5]Bloom, Fisher, and Orme, Evaluating Practice.

study could have possibly been expanded to allow the subject to become more involved with the group.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Adolescents in foster care have suffered from early familial losses, ongoing conflicts, and/or undesirable integration into surrogate families, making them particularly vulnerable to low self-esteem and self-competence/efficacy, resulting in a poor self-concept. Social workers and other professionals should identify client's strengths and achievements to enhance their client's feelings of self-esteem and self-competence/efficacy. Activities of independent living programs have developed significant relationships between the life skills training programs and the accomplishment of self-competence/efficacy.

To make progress towards independence, a young person must be comfortable discussing family relationships, feelings, and hope for the future. A regular group meeting in which these topics are discussed among young people is essential to helping youth toward independence. Social skills training as a part of Child Welfare's Independent Living Programs may provide a mechanism for changing the negative self-perceptions of foster children, thus

increasing their sense of self-esteem and self-competence/ efficacy.

APPENDIX

APPENDIX A

ROSENBERG SELF-ESTEEM SCALE (RSES)

Identification #: _____

Session #: _____

Please record the appropriate answer per item, depending on whether you strongly agree, agree, disagree, or strongly disagree.

1 = Strongly Agree
2 = Agree
3 = Disagree
4 = Strongly Disagree

____ 1. On the whole, I am satisfied with myself.

____ 2. At times, I think I am no good at all.

____ 3. I feel that I have a number of good qualities.

____ 4. I am able to do things well as most other people.

____ 5. I feel I don't have much to be proud of.

____ 6. I certainly feel useless at times.

____ 7. I feel that I am a person of worth, at least on an equal plane with others.

____ 8. I wish I could have more respect for myself.

____ 9. All in all, I am inclined to feel that I am a failure.

____ 10. I take a positive attitude toward myself.

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